(1) Physicians' services (including surgical procedures and all preoperative and postoperative services that are performed by a physician);
(2) Anesthetists' services;
(3) Radiology services (other than those integral to performance of a covered surgical procedure);
(4) Diagnostic procedures (other than those directly related to performance of a covered surgical procedure);
(5) Ambulance services;
(6) Leg, arm, back, and neck braces other than those that serve the function of a cast or splint;
(7) Artificial limbs;
(8) Nonimplantable prosthetic devices and DME.

§416.166 Covered surgical procedures.

(a) *Covered surgical procedures.* Effective for services furnished on or after January 1, 2008, covered surgical procedures are those procedures that meet the general standards described in paragraph (b) of this section (whether commonly furnished in an ASC or a physician's office) and are not excluded under paragraph (c) of this section.

(b) *General standards.* Subject to the exclusions in paragraph (c) of this section, covered surgical procedures are surgical procedures specified by the Secretary and published in the FEDERAL REGISTER and/or via the Internet on the CMS Web site that are separately paid under the OPPS, that would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC, and for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.

(c) *General exclusions.* Notwithstanding paragraph (b) of this section, covered surgical procedures do not include those surgical procedures that—
(1) Generally result in extensive blood loss;
(2) Require major or prolonged invasion of body cavities;
(3) Directly involve major blood vessels;
(4) Are generally emergent or life-threatening in nature;
(5) Commonly require systemic thrombolytic therapy;
(6) Are designated as requiring inpatient care under §419.22(n) of this subchapter;
(7) Can only be reported using a CPT unlisted surgical procedure code; or
(8) Are otherwise excluded under §411.15 of this subchapter.

[72 FR 42545, Aug. 2, 2007, as amended at 76 FR 74582, Nov. 30, 2011]

§416.167 Basis of payment.

(a) *Unit of payment.* Under the ASC payment system, prospectively determined amounts are paid for ASC services furnished to Medicare beneficiaries in connection with covered surgical procedures. Covered surgical procedures and covered ancillary services are identified by codes established under the Healthcare Common Procedure Coding System (HCPCS). The unadjusted national payment rate is determined according to the methodology described in §416.171. The manner in which the Medicare payment amount and the beneficiary coinsurance amount for each ASC service is determined is described in §416.172.

(b) *Ambulatory payment classification (APC) groups and payment weights.* (1) ASC covered surgical procedures are classified using the APC groups described in §419.31 of this subchapter.

(2) For purposes of calculating ASC national payment rates under the methodology described in §416.171, except as specified in paragraph (b)(3) of this section, an ASC relative payment weight is determined based on the APC relative payment weight for each covered surgical procedure and covered ancillary service that has an applicable APC relative payment weight described in §419.31 of this subchapter.

(3) Notwithstanding paragraph (b)(2) of this section, the relative payment weights for services paid in accordance with §416.171(d) are determined so that the national ASC payment rate does not exceed the unadjusted nonfacility practice expense amount paid under the Medicare physician fee schedule for such procedures under subpart B of part 414 of this subchapter.

§416.171 Determination of payment rates for ASC services.

(a) *Standard methodology.* The standard methodology for determining the

national unadjusted payment rate for ASC services is to calculate the product of the applicable conversion factor and the relative payment weight established under § 416.167(b), unless otherwise indicated in this section.

(1) *Conversion factor for CY 2008.* CMS calculates a conversion factor so that payment for ASC services furnished in CY 2008 would result in the same aggregate amount of expenditures as would be made if the provisions in this Subpart F did not apply, as estimated by CMS.

(2) *Conversion factor for CY 2009 and subsequent calendar years.* The conversion factor for a calendar year is equal to the conversion factor calculated for the previous year, updated as follows:

(i) For CY 2009, the update is equal to zero percent.

(ii) For CY 2010 and subsequent calendar years, the update is the Consumer Price Index for All Urban Consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(iii) *Productivity adjustment.* (A) For calendar year 2011 and subsequent years, the Consumer Price Index for All Urban Consumers determined under paragraph (a)(2)(ii) of this section is reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

(B) The application of the provisions of paragraph (a)(2)(iii)(A) of this section may result in the update being less than 0.0 for a year, and may result in payment rates for a year being less than the payment rates for the preceding year.

(b) *Exception.* The national ASC payment rates for the following items and services are not determined in accordance with paragraph (a) of this section but are paid an amount derived from the payment rate for the equivalent item or service set under the payment system established in part 419 of this subchapter as updated annually in the FEDERAL REGISTER and/or via the Internet on the CMS Web site. If a payment rate is not available, the following items and services are designated as contractor-priced:

(1) Covered ancillary services specified in § 416.164(b), with the exception of radiology services as provided in § 416.164(b)(5);

(2) Device-intensive procedures assigned to device-dependent APCs under the OPPS with device costs greater than 50 percent of the APC cost;

(3) Procedures using certain separately paid implantable devices that are approved for transitional pass-through payment in accordance with § 419.66 of this subchapter.

(c) *Transitional payment rates.* (1) ASC payment rates for CY 2008 are a transitional blend of 75 percent of the CY 2007 ASC payment rate for a covered surgical procedure on the CY 2007 ASC list of surgical procedures and 25 percent of the payment rate for the procedure calculated under the methodology described in paragraph (a) of this section.

(2) ASC payment rates for CY 2009 are a transitional blend of 50 percent of the CY 2007 ASC payment rate for a covered surgical procedure on the CY 2007 ASC list of surgical procedures and 50 percent of the payment rate for the procedure calculated under the methodology described in paragraph (a) of this section.

(3) ASC payment rates for CY 2010 are a transitional blend of 25 percent of the CY 2007 ASC payment rate for a covered surgical procedure on the CY 2007 ASC list of surgical procedures and 75 percent of the payment rate for the procedure calculated under the methodology described in paragraph (a) of this section.

(4) The national ASC payment rate for CY 2011 and subsequent calendar years for a covered surgical procedure designated in accordance with § 416.166 is the payment rates for the procedure calculated under the methodology described in paragraph (a) of this section.

(5) Covered ancillary services described in § 416.164(b) and surgical procedures identified as covered when performed in an ASC under § 416.166 for the first time beginning on or after January 1, 2008, are not subject to the transitional payment rates applicable in CYs 2008 through 2010 for ASC facility services.

(d) *Limitation on payment rates for office-based surgical procedures and covered ancillary radiology services.* Notwithstanding the provisions of paragraph

(a) of this section, for any covered surgical procedure under §416.166 that CMS determines is commonly performed in physicians' offices or for any covered ancillary radiology service, excluding those listed in paragraphs (d)(1) and (d)(2) of this section, the national unadjusted ASC payment rates for these procedures and services will be the lesser of the amount determined under paragraph (a) of this section or the amount calculated at the nonfacility practice expense relative value units under §414.22(b)(5)(i)(B) of this subchapter multiplied by the conversion factor described in §414.20(a)(3) of this subchapter.

(1) The national unadjusted ASC payment rate for covered ancillary radiology services that involve certain nuclear medicine procedures will be the amount determined under paragraph (a) of this section.

(2) The national unadjusted ASC payment rate for covered ancillary radiology services that use contrast agents will be the amount determined under paragraph (a) of this section.

(e) *Budget neutrality.* (1) For CY 2008, CMS establishes the conversion factor to result in budget neutrality as estimated by CMS in accordance with paragraph (a)(1) of this section.

(2) For CY 2009 and subsequent calendar years, CMS adjusts the ASC relative payment weights under §416.167(b)(2) as needed so that any updates and adjustments made under §419.50(a) of this subchapter are budget neutral as estimated by CMS.

[72 FR 42545, Aug. 2, 2007, as amended at 75 FR 72264, Nov. 24, 2010; 76 FR 74582, Nov. 30, 2011; 77 FR 277, Jan. 4, 2012]

§416.172 Adjustments to national payment rates.

(a) *General rule.* Contractors adjust the payment rates established for ASC services to determine Medicare program payment and beneficiary coinsurance amounts in accordance with paragraphs (b) through (g) of this section.

(b) *Lesser of actual charge or geographically adjusted payment rate.* Payments to ASCs equal 80 percent of the lesser of—

(1) The actual charge for the service; or

(2) The geographically adjusted payment rate determined under this subpart.

(c) *Geographic adjustment*—(1) *General rule.* Except as provided in paragraph (c)(2) of this section, the national ASC payment rates established under §416.171 for covered surgical procedures are adjusted for variations in ASC labor costs across geographic areas using wage index values, labor and nonlabor percentages, and localities specified by the Secretary.

(2) *Exception.* The geographic adjustment is not applied to the payment rates set for drugs, biologicals, devices with OPPS transitional pass-through payment status, and brachytherapy sources.

(d) *Deductibles and coinsurance.* Part B deductible and coinsurance amounts apply as specified in §§410.152(a) and (i)(2) of this subchapter.

(e) *Payment reductions for multiple surgical procedures*—(1) *General rule.* Except as provided in paragraph (e)(2) of this section, when more than one covered surgical procedure for which payment is made under the ASC payment system is performed during an operative session, the Medicare program payment amount and the beneficiary coinsurance amount are based on—

(i) 100 percent of the applicable ASC payment amount for the procedure with the highest national unadjusted ASC payment rate; and

(ii) 50 percent of the applicable ASC payment amount for all other covered surgical procedures.

(2) *Exception: Procedures not subject to multiple procedure discounting.* CMS may apply any policies or procedures used with respect to multiple procedures under the prospective payment system for hospital outpatient department services under Part 419 of this subchapter as may be consistent with the equitable and efficient administration of this part.

(f) *Interrupted procedures.* When a covered surgical procedure or covered ancillary service is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment